

C. Christopher Allen, Ph.D., P.S.C.
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FAX COVER SHEET**Date:** 11-1-2013**# of Pages:** 3
(including cover sheet)**To:****Co/Dept:****Fax #:** 203-306-3014**Phone #:****MESSAGE**

Re: Release of info

Confidentiality Notice

This facsimile contains privileged and confidential information intended only for the use of the individual or entity noted above and may contain information that is privileged or exempt from disclosure under applicable law. If you are not a named addressee, you are hereby notified that any review, use, dissemination, distribution or copying of this transmission is strictly prohibited under applicable state and federal law. If you have received this transmission in error, please destroy all copies and notify us immediately at the above number. Thank you.

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To whom it may concern:

We received a request for information from this fax number, but it did not include the name of the patient. I have attached a release form, and will need a copy of the requester's ID. If this is a public fax number, then please disregard this fax. Otherwise, if you have questions, please feel free to call or fax our office.

Thank you,

Office of C. Christopher Allen, Ph.D.

C. Christopher Allen, Ph.D.
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AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize Dr. Allen and/or his administrative and clinical staff to release (please circle all that apply), progress notes, reports, information via professional communication (i.e. phone, mail or e-mail).

This information should be released to (fill in the name, address, and phone number of person to whom the information is to be released).

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until (fill in expiration date) ____/____/_____, or until (any event which relates to the individual or the purpose of the user or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure (i.e., disclosed by the recipient of this information to a designated third party) by the recipient of your information and no longer protected by the HIPAA Privacy Rules.

X _____
signature of patient

date

If the authorization is signed by a personal representative (i.e., parent, guardian, etc.) of the patient, a description of such representative's authority to act for the patient must be provided.

Note: A parent or guardian must fill out these forms and sign for anyone under 18.